# Confidential Senior Health Questionnaire

*If you are unsure about any terms, feel free to ask for help.*

Name: _____ DOB: _____ Current Date: _____

Sex/Gender: _____ Pronouns: _____ Sexual Orientation: _____

*(Use your preferred term, ex.: male, trans woman, nonbinary, N/A, etc.)* *(optional, ex.: he, she, they)* *(ex.: heterosexual, lesbian, bi, asexual, etc.)*

*Please mark "yes" or "no" if you are currently experiencing or have ever experienced the following conditions, or fill in requested information as appropriate. Write "NA" if not applicable.*

## CLINIC/HOSPITAL VISIT HISTORY

Have you seen another health care provider in the last year? ◯ No ◯ Yes

Who/Where : _____ When: _____ Reason: _____

Who/Where : _____ When: _____ Reason: _____

Have you been hospitalized, visited an ER, or undergone any surgery in the last year? ◯ No ◯ Yes

Where : _____ When: _____ Reason: _____

Where : _____ When: _____ Reason: _____

## MEDICAL HISTORY

Do you have: (*Please check all that apply)*

| | | | |
|---|---|---|---|
| ◯ High Blood Pressure | ◯ Heart Disease | ◯ Respiratory Disease | ◯ Blood Disease |
| ◯ High Cholesterol | ◯ Heart Murmur | ◯ Asthma | ◯ Anemia |
| ◯ Gallstones | ◯ Kidney Disease | ◯ Osteoporosis/Bone Problems | ◯ Blood Transfusion |
| ◯ Diabetes | ◯ Neurological Disease | ◯ Stomach or Bowel Disease | ◯ Hepatitis |
| ◯ Cancer | ◯ Psychiatric Disorders | ◯ Urinary Tract Infections | ◯ Varicose Veins |
| ◯ Skin Disease | ◯ Headaches | ◯ Seizures | ◯ Rectal Bleeding |
| ◯ Thyroid Problem | ◯ Blood Clots *(legs, lungs, other sites [other than menstrual bleeding])* | | |

◯ Allergies Please list: _____

◯ Are you allergic to any medication? _____

Are you taking any medication regularly: ◯ No ◯ Yes

Please list all medications, including over-the counter medications (like ibuprofen), vitamins, and supplements:

_____

_____

Have you had any prior major illnesses or surgeries? ◯ No ◯ Yes

_____

_____

## EXAM & VACCINATION HISTORY

| When was your last: | Date: | Or: | When were you last vaccinated for: | | |
|---|---|---|---|---|---|
| Physical? | _____ | ◯ Don't remember ◯ N/A | Flu? | _____ | ◯ Don't remember ◯ N/A |
| Cholesterol test? | _____ | ◯ Don't remember ◯ N/A | Pneumonia? | _____ | ◯ Don't remember ◯ N/A |
| Colonoscopy? | _____ | ◯ Don't remember ◯ N/A | Tetanus? | _____ | ◯ Don't remember ◯ N/A |
| DEXA scan? *(osteoporosis screening)* | _____ | ◯ Don't remember ◯ N/A | | _____ | ◯ Don't remember ◯ N/A |

## SOCIAL HISTORY

Are you currently employed? ◯ No ◯ Yes
Occupation: _____

Are there occupational hazards at your workplace? ◯ No ◯ Yes
*(asbestos, chemicals/fumes, excessive noise, etc.)*

Do you drink alcohol? ◯ No ◯ Yes How many drinks? _____ How often? _____

Do you smoke cigarettes? ◯ No ◯ Yes How many ( cigarettes / packs ) do you smoke per day? _____
*(circle one)*

Do you exercise regularly? ◯ No ◯ Yes How long? _____ How often? _____

Do you take calcium? ◯ No ◯ Yes How much? _____ How often? _____

Do you: ◯ Drink Coffee/Soda/Energy Drinks? How much? _____ How often? _____
◯ Take caffeine pills/other supplements? How much? ____ How often? ____

Do you use street drugs? ◯ No ◯ Yes Do you use injection drugs? ◯ No ◯ Yes

Is anyone hurting, threating, or abusing you? ◯ No ◯ Yes ◯ Decline to state on this form.

Have you ever been physically, emotionally, or sexually abused, or forced to have sex? ◯ No ◯ Yes ◯ Decline

## FAMILY HISTORY

Please indicate if on Mother's (M) or Father's (F) side of the family. If adopted (family unknown) check here ◯.

| | Side: | Relation: | Date: | | Side: | Relation: | Date: |
|---|---|---|---|---|---|---|---|
| ◯ Diabetes | M F | | | ◯ Stroke (before 50) | M F | | |
| ◯ Down's syndrome | M F | | | ◯ Stroke (after 50) | M F | | |
| ◯ Gallbladder disease | M F | | | ◯ Tay-Sachs disease | M F | | |
| ◯ Heart disease | M F | | | ◯ Genetic disease | M F | | |
| ◯ Cancer | M F | | | Type of Cancer: _____ | | | |

## SEXUAL HISTORY

*Note: You are not obligated to disclose the gender identity of any of your sexual partners, including your current partner, on this form.*

Are you sexually active? ◯ No ◯ Yes Age at first intercourse: ____ Number of sex partners in the last year: _____

Are you sexually active with: *(mark all that apply)* ◯ Women ◯ Men ◯ Partners of Other Genders

Do you currently have a sex partner? ◯ No ◯ Yes If so, how long have you been with them? _____

Does your current sex partner have: Other sex partners? ◯ No ◯ Yes Male sex partners? ◯ No ◯ Yes

Indicate if any of your current or previous sex partners are: ◯ Injection Drug Users ◯ Prostitutes

## CONTRACEPTIVE HISTORY

Current Method: _____

Do you want to change your method? ◯ No ◯ Yes

Check other methods of birth control used in the past. Input approximate dates and any problems you may have had

| Select | Type | Date used | Problems, if any | Select | Type | Date used | Problems, if any |
|---|---|---|---|---|---|---|---|
| ◯ | Pills (Name) | | | ◯ | Condoms | | |
| ◯ | IUD | | | ◯ | Ring/Patch | | |
| ◯ | Diaphragm | | | ◯ | Depo-Provera | | |
| ◯ | Foam/Film | | | ◯ | Rhythm/NAP | | |

## SEXUALLY TRANSMITTED INFECTIONS HISTORY

Have you had the hepatitis B vaccine? (total 3 injections) ◯ No ◯ Yes, date: _____

Have you ever been treated for any of the following STIs?

◯ Chlamydia, date: _____ ◯ Gonorrhea, date: _____ ◯ HIV/AIDS, date: _____

◯ Syphilis, date: _____ ◯ Herpes, date: _____ ◯ Genital warts (HPV), date: _____

Have any of your current or past sex partners been treated for any of the following STIs in the past (or currently)?

◯ Chlamydia, date: _____ ◯ Gonorrhea, date: _____ ◯ HIV/AIDS, date: _____

◯ Syphilis, date: _____ ◯ Herpes, date: _____ ◯ Genital warts (HPV), date: _____

## HORMONAL, MENSTRUAL, AND REPRODUCTIVE HEALTH/HISTORY

Are you currently experiencing any pelvic pain? ◯ No ◯ Yes, where/what kind of pain: _____

Have you ever had any pelvic surgery? ◯ No ◯ Yes, type of surgery: _____

Tubal ligation? ◯No ◯Yes Hysterectomy? ◯No ◯Yes If yes, circle what kind: Total or Partial

Are you currently using birth control pills? (for any reason, such as PMS/PMDD treatment) ◯ No ◯ Yes

Are you currently undergoing Hormone Replacement Therapy (HRT), for any reason? ◯ No ◯ Yes

Have you been exposed to DES (diethylstilbestrol)? (1938-1971) ◯ No ◯ Yes

**Mark here if the rest of this section does not apply:** ◯ Note why, if desired: _____

Have you undergone menopause? ◯No ◯Yes, age: _____ Any post-menopausal bleeding? ◯No ◯Yes

Age menstruation began: _____ Date of 1st day of last menstrual period: _____

Usual cycle occurs every _____ days. Usual cycle flows for _____ days.

Usual cramps: ◯ Light ◯ Medium ◯ Heavy Usual flow: ◯ Light ◯ Medium ◯ Heavy

Date of last pap smear: _____ Have you ever had an abnormal pap smear? _____

Are you able to conceive? ◯ No ◯ Yes Total # of pregnancies (regardless of outcome): _____

# of each outcome: Live births:_____ Abortions:_____ Cesarean Sections:_____ Miscarriages:_____

If applicable, have you had unprotected sex since your last period? ◯ No ◯ Yes , date: _____

## URINARY/GENITAL HEALTH HISTORY

Have you been experiencing:

Difficulty starting a stream of urine? ◯ No ◯ Yes Blood in your urine? ◯ No ◯ Yes

Getting up at night to urinate? ◯ No ◯ Yes Frequent urination? ◯ No ◯ Yes

**Mark here if the rest of this section does not apply:** ◯ Note why, if desired: _____

Do you have a history of undescended testicle? ◯ No ◯ Yes ◯ N/A

Do you have a history of impotency? ◯ No ◯ Yes ◯ N/A

Do you have a lump in your testicle? ◯ No ◯ Yes ◯ N/A

Are you experiencing any prostate problems? ◯ No ◯ Yes ◯ N/A (If 50+) Date of last prostate exam:_____

## BREAST HEALTH HISTORY

Date of last breast exam: _____ Date of last mammogram: _____

Do you have a history of breast problems? ◯ No ◯ Yes, when: _____

Do you have a family history of breast cancer? ◯ No ◯ Yes, who: _____

Do you have a history of breast surgery? ◯ No ◯ Yes, when: _____

What types of breast surgery? _____

## PRESENTING PROBLEM(S)

Indicate below any current symptoms/issues you are experiencing. Sign below when you have finished.

### GENERAL HEALTH

Have you recently experienced:

| | | |
|---|---|---|
| Fever: | ◯ No | ◯ Yes |
| Chills: | ◯ No | ◯ Yes |
| Sweating: | ◯ No | ◯ Yes |
| Recent weight change: | ◯ No | ◯ Yes |

### SKIN

Have you recently experienced:

| | | |
|---|---|---|
| Acne: | ◯ No | ◯ Yes |
| Change in pigment/mole: | ◯ No | ◯ Yes |
| History of skin cancer/melanoma: | ◯ No | ◯ Yes |
| Rash(es): | ◯ No | ◯ Yes |

### VISION

Have you recently experienced:

| | | |
|---|---|---|
| Blurred vision: | ◯ No | ◯ Yes |
| Cataract(s): | ◯ No | ◯ Yes |
| Glaucoma: | ◯ No | ◯ Yes |
| Itchy/watery eyes: | ◯ No | ◯ Yes |

### HEMATOLOGY

Have you recently experienced:

| | | |
|---|---|---|
| Anemia: | ◯ No | ◯ Yes |
| Easy bruising: | ◯ No | ◯ Yes |
| Heavy bleeding: | ◯ No | ◯ Yes |
| History of blood transfusion: | ◯ No | ◯ Yes |

### EARS, NOSE, THROAT

Have you recently experienced:

| | | |
|---|---|---|
| Bleeding gums: | ◯ No | ◯ Yes |
| Ear pain: | ◯ No | ◯ Yes |
| Hearing loss: | ◯ No | ◯ Yes |
| Hoarseness: | ◯ No | ◯ Yes |
| Itchy nose, sneezing: | ◯ No | ◯ Yes |
| Nasal discharge, congestion: | ◯ No | ◯ Yes |
| Ringing in your ears: | ◯ No | ◯ Yes |

### CARDIO-RESPIRATORY

Have you recently experienced:

| | | |
|---|---|---|
| Chest pain: | ◯ No | ◯ Yes |
| Chronic cough: | ◯ No | ◯ Yes |
| Heart murmur: | ◯ No | ◯ Yes |
| High blood pressure: | ◯ No | ◯ Yes |
| High cholesterol: | ◯ No | ◯ Yes |
| History of heart attack: | ◯ No | ◯ Yes |
| Shortness of breath: | ◯ No | ◯ Yes |

### GASTRO-INTESTINAL

Have you recently experienced:

| | | |
|---|---|---|
| Abdominal pain: | ◯ No | ◯ Yes |
| Black or bloody stool: | ◯ No | ◯ Yes |
| Constipation: | ◯ No | ◯ Yes |
| Diarrhea: | ◯ No | ◯ Yes |
| Gallbladder disease: | ◯ No | ◯ Yes |
| Heartburn: | ◯ No | ◯ Yes |
| Nausea/vomiting: | ◯ No | ◯ Yes |
| Ulcer disease: | ◯ No | ◯ Yes |

### ENDOCRINE

Have you recently experienced or been diagnosed with:

| | | |
|---|---|---|
| Diabetes: | ◯ No | ◯ Yes |
| Obesity: | ◯ No | ◯ Yes |
| Thyroid problem: | ◯ No | ◯ Yes |

### MUSCULO-SKELETAL

Have you recently experienced:

| | | |
|---|---|---|
| Back pain: | ◯ No | ◯ Yes |
| Joint pain: | ◯ No | ◯ Yes |
| Leg cramps: | ◯ No | ◯ Yes |

### NEURO/PSYCHIATRIC

Have you recently experienced or been diagnosed with:

| | | |
|---|---|---|
| Depression: | ◯ No | ◯ Yes |
| Dizziness: | ◯ No | ◯ Yes |
| Headaches: | ◯ No | ◯ Yes |
| History of stroke: | ◯ No | ◯ Yes |
| Seizure: | ◯ No | ◯ Yes |

### GENITO-URINARY

Have you recently experienced:

| | | |
|---|---|---|
| Burning during urination: | ◯ No | ◯ Yes |
| Unusual vaginal discharge: | ◯ No | ◯ Yes |
| Unusual vaginal bleeding: | ◯ No | ◯ Yes |
| Pain during sex: | ◯ No | ◯ Yes |

**Do you have any other health concerns?** _____

**Please sign below:**

_____ _____

Patient's Signature Date